

- 4 Gopalan S, Bagga R, Jain V, *et al.* Antenatal HIV testing—results of a pilot study from North India. *J Obst Gynaecol Ind* 2000;50:40–4.
- 5 Bang RA, Bang AT, Baitule M, *et al.* High prevalence of gynaecological diseases in rural Indian women. *Lancet* 1989;1:85–8.
- 6 Zurayk H, Khattab H, Younis N, *et al.* Comparing women's reports with medical diagnosis of reproductive morbidity condition in rural Egypt. *Stud Fam Plann* 1995;26:14–21.
- 7 Wasserheit JN, Harris JR, Chakraborty J, *et al.* Reproductive tract infections in a family planning population in rural Bangladesh. *Stud Fam Plann* 1989;20:69–80.
- 8 Meheus A, De Schrijver A. Sexually transmitted diseases in the third world. In: Harris JRW, Forster SM, eds. *Recent advances in sexually transmitted diseases and AIDS*. New York: Churchill Livingstone, 1991:201–17.

Chaperoning in genitourinary medicine: supporting patients and protecting doctors

I read with interest the result of the postal survey regarding chaperoning in genitourinary medicine (GUM) clinics.¹ The notable observation is that female patients were offered a chaperone far more often than males (on all occasions when the examiner was a male (32/32) and frequently when the examiner was a female (13/40)). Chaperoning was offered less frequently when the patient was a male with a female examiner (7/37) and infrequently with a male examiner (3/39).

GUM nurses and doctors are particularly vulnerable because the open access of the services exposes them to situations where they have no prior knowledge of the patient's background, social, behavioural, psychological, or mental state. The vulnerability is accentuated by the fact that sexual history and intimate examination are part of the routine clinical assessment in most of the situations. This vulnerability was called into a course of action in our clinic in 1996 when a senior male clinical assistant was a recipient of allegations (from a male patient in his 50s). The clinical assistant was nearing retirement, after an unblemished long service in general practice, with over 20 years' experience as an assistant in GUM. The patient expressed extremes of behaviour, grandiose imagination, and swings of mood, which became a reason for clinical concern. The concerns were raised with the patient's general practitioner (GP) who advised that the patient suffered problems with alcoholism and was undergoing mental rehabilitation, and that he would attend the patient's condition urgently at home. The GP telephoned the clinic later to indicate that the patient had recovered from his episode and he would like to speak with the consultant GU physician. The patient offered a clear and strong apology regarding what he described as "inappropriate course of behaviour and action" and reiterated that his initial allegations against the senior clinical assistant were, in all, unsafe and untrue.

The incident of false allegations has proved the particular vulnerability of doctors and nurses in the GUM clinic setting. A review of the procedures of chaperoning in the GUM clinic was conducted. The clinic then introduced a system of guidelines whereby all clinical examinations and tests are done in the presence of a chaperone (irrespective of the sex of the patient or the examiner). The nursing staff have realised and appreciated the benefits of attendance to support the

patients and to assist the doctors (during the clinical examination and tests). The time spent in the clinical room proved useful in the preparation and labelling of samples. Gaining knowledge about the clinical assessment of clients proved to be valuable to nurses during health advising. The application of the named nurse procedures has meant that the attending nurse would follow the patient all through the clinical assessment, microscopic tests, the introduction of treatment/therapy, and health advising thereafter. This continuity of care is more acceptable to the patient and more satisfactory to the nursing staff.

The issue of funding for chaperoning could be argued under the remit of professional safety. Professionals in other services take stringent methods to protect themselves from what could be less dangerous and damaging situations to their professional careers. Therefore, chaperoning in GUM must be viewed in the light of providing support to patients and protection to staff.

A R Markos

Mid Staffordshire General Hospitals NHS Trust,
Staffordshire General Hospital, Weston Road,
Stafford ST16 3SA, UK; Stephanie.thorpe@
msgh-tr.wmids.nhs.uk

Accepted for publication 30 June 2003

Reference

- 1 Miller R, Jones K, Daniels D, *et al.* Chaperoning in genitourinary medicine clinics. *Sex Transm Infect* 2003;79:74–5.

STI case management at a South African teaching hospital

In South Africa, KwaZulu-Natal (KZN) is at the centre of the HIV epidemic and sexually transmitted infections (STIs) are endemic in this province.¹ Improving the quality of STI health care causes a cost effective reduction in HIV prevalence and STI incidence.² Despite the introduction of national standard treatment guidelines (STGs), based on the syndromic management approach (where antibiotics are prescribed according to algorithms and non-medicinal aspects of care are emphasised), poor case management has been found in rural KZN clinics.³ This study determined the quality of care received by STI patients at King Edward VIII Hospital (KEH), Durban. As the province's main academic hospital, KEH has represented the best level of health care for the average citizen of KZN since 1936. Patients with STI are managed syndromically.

The drug treatment of 97 black African outpatients with STI (73% female, average age 29 years) was compared with STGs. Patients also completed a questionnaire assessing non-drug management. Drug treatment complied with STGs in 79% of patients. When assessment included non-drug measures (partner notification cards, condoms, and correct drugs) it fell to 24% compared to 9% found among nurses, with simulated patients in rural KZN clinics.³ Although overall care appears better in the urban setting, the real difference is at the level of drug treatment (where 79% v 41% received recommended drugs), as in both cases only about a quarter of the patients who had correct drug treatment also received appropriate non-drug care. Patients had appropriate counselling in 56% of cases. This was measured in terms of receiving at least one message in each of the five categories shown in table 1. Despite 72% of patients being encouraged to use condoms, 52 patients were not shown how to do this. Of these, only 31 knew how to use them.

Care givers were interviewed and vignettes were used to compare ideal and actual practice. Barriers to patient care and possible solutions were canvassed. All care givers gave appropriate answers for the ideal management of their fictitious case, but reported a difference between ideal management and actual practice in terms of non-drug aspects of management. All care givers failed to give drug information and to promote health seeking behaviour. Barriers to patient care were lack of time, staffing shortages, and motivation. There was a perception that non-drug management was not the responsibility of the tertiary care giver.

Care givers favoured the option of introducing a packet containing information, condoms, and a referral card, which could be issued with medication. In rural KZN a similar intervention resulted in improved case management in 83% of cases compared with a control group of 12% ($p < 0.005$).⁴ Such packets could help improve STI management in this tertiary setting, which has no dedicated STI clinic.

Acknowledgements

The authors wish to thank the interviewers, the staff of KEH, and the patients who participated, as well as Immo Kleinschmidt and Andy Gray who gave statistical advice.

C S Harries, J Botha

Department of Pharmacology, Nelson R Mandela School of Medicine, University of Natal, Private Bag X7, Congella, 4013, Durban, KwaZulu-Natal, South Africa

Table 1 Categories of patient counselling showing one important example in each category

Counselling category	Example	"Yes" response (%)	95% CI
Drug information	Told to take medicine	65	55 to 74
Partner referral	Told partner must be treated	56	45 to 66
Health seeking behaviour	Told about the signs of STI	50	39 to 60
Risk reduction	Told that STI enhances HIV risk	57	46 to 67
Condom promotion	Encouraged to use condoms	72	62 to 81

M L McFadyen

Clinical Sciences, Pfizer Global Research and Development, Sandwich, Kent, CT13 9NJ, UK

A Harrison

South African Medical Research Council HIV Prevention Research Unit, Durban, KwaZulu-Natal, South Africa

Correspondence to: Katy Harries, Department of Pharmacology, Nelson R Mandela School of Medicine, University of Natal, Private Bag X7, Congella, 4013, Durban, KwaZulu-Natal, South Africa; harriesk@nu.ac.za

Accepted for publication 10 July 2003

References

- 1 Day C, Gray A. Health and related indicators. In: Ntuli A, Suleman F, Barron P, McCoy D, eds. *South African Health Review 2001*. Durban: Health Systems Trust, 2001:283–340.
- 2 Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial. *Lancet* 1995;346:530–6.
- 3 Harrison A, Wilkinson D, Lurie M, et al. Improving quality of sexually transmitted disease case management in rural South Africa. *AIDS* 1998;12:2329–35.
- 4 Harrison A, Abdool Karim S, Floyd K, et al. Syndrome packets and health worker training improve sexually transmitted disease case management in rural South Africa: randomised controlled trial. *AIDS* 2000;14:2769–79.

Male circumcision in Britain: findings from a national probability sample survey

Studies from developing countries¹ and sexually transmitted diseases clinics in developed countries² show that male circumcision appears to protect against some ulcerative sexually transmitted infections (STIs) and decreases the risk of HIV infection.³ We used data from the 2000 British National Survey of Sexual Attitudes and Lifestyles (Natsal 2000)—a large scale, stratified, probability sample survey—to estimate the prevalence of male circumcision in Britain and investigate its association with key demographic characteristics, sexual behaviours, and

reported STI diagnosis. Natsal 2000 methodology details are published elsewhere.⁴ For the purposes of this investigation, data from targeted oversampling of black Caribbean, black African, Indian, and Pakistani groups (the Natsal ethnic minority boost) were combined with the main survey data in order to increase the numbers of these respondents included in the analysis. All data were weighted to be representative of the British population and analyses were performed using Stata version 6.0 to take into consideration Natsal 2000's complex survey design.⁴

We found 15.8% (95% confidence interval (CI) 14.7 to 17.1) of British men aged 16–44 years reported being circumcised in Natsal 2000. Age specific prevalence was greatest among men aged 40–44 years (19.6%, 95% CI 16.8 to 22.7) compared to those aged 16–19 years (11.7%, 95% CI 9.0 to 15.2). With the exception of black Caribbeans, men from all ethnic minority backgrounds were significantly more likely to report being circumcised compared to men who described their ethnicity as white ((adjusting for demographic variables: age, global region of birth, ethnicity, residence in London, religion, and qualifications) adjusted odds ratio (OR) for self reporting ethnicity as other than white 3.02, 95% CI 2.39 to 3.81, $p < 0.001$). In addition, men born abroad instead of in Britain were significantly more likely to be circumcised ((adjusting for demographic variables: age, global region of birth, ethnicity, residence in London, religion, and qualifications) adjusted OR 1.74, 95% CI 1.25 to 2.42, $p < 0.001$). Significant ($p < 0.001$) variations in the prevalence of circumcision were also observed across the major religious groups, with prevalence being greatest among Jewish men (98.7%, 95% CI 90.1 to 99.8) and lowest among Hindus, Sikhs, and Buddhists (9.8%, 95% CI 4.7 to 9.3). Relative to uncircumcised men, circumcised men were more likely to report having had homosexual partner(s) (7.5% v 5.3%, $p = 0.012$) and partners from abroad (19.7% v 13.1%, $p < 0.001$).

We did not find any significant differences in the proportion of circumcised and uncircumcised British men reporting ever being diagnosed with any STI (11.1% compared with 10.8%, $p = 0.815$), bacterial STIs (6.4%

cf 5.9%, $p = 0.628$), or viral STIs (4.7% cf 4.5%, $p = 0.786$) (table 1). We also found no significant associations between circumcision and being diagnosed with any one of the seven specific STIs.

Our findings confirm that the prevalence of male circumcision among British men appears to be declining. This is despite an increase in the proportion of the British population describing their ethnicity as non-white.⁵ The lack of association between circumcision status and STI history in this population is consistent with findings from other developed countries⁶ and may be because of relatively low prevalence of STIs in this setting, as well as the relatively small proportion of the population who are circumcised.

Acknowledgements

We thank the study participants, the team of interviewers and operations, and computing staff from the National Centre for Social Research who carried out the interviews.

Contributors

SD drafted the paper and participated in the statistical analysis, with contributions from CM; KF, AJ, KW, and RE were co-investigators and participated in the design and management of the main study.

S S Dave

The Mortimer Market Centre, Camden Primary Care Trust, off Copper Street, London WC1E 6AU, UK

A M Johnson, K A Fenton, C H Mercer

Centre for Infectious Disease Epidemiology, Department of Primary Care and Population Sciences and Department of Sexually Transmitted Diseases, Royal Free and University College Medical School, Mortimer Market Centre, off Copper Street, London WC1E 6AU, UK

B Erens

National Centre for Social Research, 35 Northampton Square, London EC1V 0AX, UK

K Wellings

London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

Correspondence to: Dr Sangeeta S Dave, Camden Primary Care Trust, Mortimer Market Centre, off Copper Street, London WC1E 6AU, UK; Sangeeta.Dave@camdenpct.nhs.uk

Table 1 Cumulative incidence of reported previous STI diagnosis by circumcision status among men aged 16–44 years in Britain (Natsal 2000*)

	Uncircumcised†%	Circumcised†%	OR for being circumcised	
	(95% CI)	(95% CI)	(95% CI)	p Value
Any STI‡	10.8 (9.8 to 12.0)	11.1 (9.0 to 13.7)	1.03 (0.80 to 1.34)	0.815
Any bacterial STI§	5.9 (5.1 to 6.8)	6.4 (4.8 to 8.5)	1.09 (0.77 to 1.55)	0.628
Any viral STI¶	4.5 (3.8 to 5.3)	4.7 (3.4 to 6.6)	1.05 (0.72 to 1.55)	0.789
Gonorrhoea	1.1 (0.8 to 1.6)	1.5 (0.8 to 2.6)	1.31 (0.67 to 2.58)	0.432
Genital chlamydia	1.5 (1.1 to 1.9)	1.2 (0.7 to 2.2)	0.81 (0.41 to 1.61)	0.555
Syphilis	0.2 (0.0 to 0.6)	0.3 (0.0 to 1.0)	1.29 (0.27 to 6.05)	0.748
Non-specific urethritis	3.5 (2.8 to 4.2)	4.0 (2.7 to 5.9)	1.17 (0.74 to 1.84)	0.501
Genital herpes	1.0 (0.8 to 1.4)	1.1 (0.6 to 2.3)	1.10 (0.51 to 2.38)	0.804
Genital warts	3.6 (3.0 to 4.3)	3.8 (2.6 to 5.5)	1.04 (0.67 to 1.63)	0.858
Trichomonas	0.4 (0.2 to 0.7)	0.1 (0.0 to 0.5)	0.26 (0.04 to 1.62)	0.148

*In addition to the main Natsal 2000 sample, an additional sample (unweighted/weighted) of 406/299 men from black Caribbean, black African, Indian, and Pakistani ethnic groups were recruited in order to provide more robust estimates for these population groups.

†Unweighted/weighted bases for uncircumcised men are 4833/3795, respectively, and for circumcised men are 913/982, respectively.

‡Gonorrhoea, genital chlamydia, syphilis, non-specific urethritis, genital herpes, genital warts, and trichomonas.

§Gonorrhoea, genital chlamydia, syphilis, and non-specific urethritis.

¶Genital herpes and genital warts.